**CERTIFICATION OF HEALTH CARE PROVIDER**
**FOR GENERAL MEDICAL LEAVE OF ABSENCE**

This form should be submitted by any employee requesting a general medical leave of absence under Department of Personnel Administrative Regulation No. 122. This form is NOT to be used when requesting a Family/Medical of Absence. If a Family/Medical Leave of Absence is being requested, see Department of Personnel Administrative Regulation No. 133.

**SECTION I** To be completed by employee

1. Name of employee: _____

2. Employee's job class: _____
(The employee must provide his/her Health Care Provider with a copy of the employee's job description along with this form.)

_____ _____
**Employee's Signature** **Date**

**SECTION II** To be completed by the employee's Health Care Provider

1. Pease describe the medical condition(s) that necessitates a medical leave of absence for employee:
_____

_____

2. Are you treating, or overseeing the treatment of, this employee for the medical condition that necessitates the employee's work restrictions? ____ If not, or if another health care provider is also treating this employee or overseeing such treatment, please provide the name, type of practice and address of each such health care provider:
_____

3. Date of employee's next scheduled visit with you: _____

4. Date condition commenced or will commence: _____

5. Please describe the treatment prescribed or to be prescribed during employee's medical leave of absence (i.e., general nature of treatment, frequency and duration of treatment):
_____

_____

_____

_____

6 Probable date employee will be able to return to work with or without restrictions (please use your best judgment. Do not answer "unknown"):_____

7. If you anticipate that this employee will have restrictions when he/she returns to work, please list those restrictions and any tasks or job functions listed in the employee's job description that he/she will be unable to perform and the probable date those restrictions will end:

_____

_____

GINA DISCLAIMER

Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b)

_____ _____

**Signature of Health Care Provider** **Date**

Printed Name of Health Care Provider: _____

Type of Practice: _____

Address: _____

Phone Number: _____

(01/21/2020)